Pregnancy Notification Form (Post-delivery Pregnancy Notification Form)

*Please fill out the bold area below.

Maternity Passbook #	

Kana Syllables / Mother's Name		DOB	(dd/ mm/ yyyy) (Age:)	
Address	Hachioji City / Phone (Telephone/Mobile)		Occupation	
Weeks of Pregnancy	Weeks (Months)	Expected Date of Delivery (Date of Delivery)	(dd/mm/yyyy)	
Health checkup regarding STDs (Blood test)	☐ Already tested ☐ Not yet	Health checkup regarding tuberculosis (Chest X-ray)	☐ Already tested ☐ Not yet	
Have you already been diagnosed by a physician or midwife?	☐ Yes Facility Name Address Name *State the name of hospital/medical institution/clinic/maternity center in the section above.		☐ No	
Number of Pregnancy	☐ The first time ・ ☐ ( ) time (s)			

I hereby notify you as above.

(dd/mm/yyyy)

Informant ____________________

(State your relationship with the woman if you are submitting this form on behalf of her)

To the Mayor of Hachioji

*Please complete the following section if you are submitting this form as a post-delivery pregnancy notification.

Kana Syllables / Child's Name		DOB	(dd/mm/yyyy) (Age: year (s) month (s))

***The following is a questionnaire for pregnant women. Please tell us your condition and feelings.**

We aim to support you from the start of pregnancy to help you raise your child. Please note that this information will be managed by Health and Welfare Center and will not be used for purposes other than our delivery and childcare services. Your kind cooperation is greatly appreciated.

1. Is everything going well with your pregnancy? Yes / No (Reason:)
2. How do you feel about this pregnancy? (Multiple choices allowed)
   (a) Happy (b) Unhappy (c) Anxious (d) Others
   Tell us more: ( )
3. Do you have someone to help you with this pregnancy and delivery? Yes / No
   If yes, who is it? (My partner / parent / brother or sister / friend / Others ____________)
4. Do you wish to receive advice from our health nurse regarding your pregnancy or delivery?
   No
   Yes Tell us more: ( )
   ◆Please indicate someone who can respond to our call in Japanese.
   Phone: - - Name: Relationship:

*Please note that our health nurse may visit you according to the information on this survey form.

25.08

・・・・・・・・FOR CITY USE ONLY (DO NOT WRITE)・・・・・・・・

❑大横保健福祉センター ❑市民課 ❑南口総合 ❑石川 ❑加住
❑東浅川保健福祉センター ❑浅川 ❑横山 ❑館 ❑元八 ❑恩方 ❑川口
❑南大沢保健福祉センター ❑由木 ❑由木東 ❑南大沢 ❑北野 ❑由井